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Regionalization of Perinatal Care in Orange County, California

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IN JANUARY 1975 the Orange County (California) Medical Association sponsored a symposium on regionalization of perinatal care in Orange County. At the time of this meeting it appeared that many physicians were confused, threatened and often antagonized by the concept. The purpose of this paper is to examine the problem of regionalization in Orange County, with the thought that the situaton in this area may serve as a model for other areas.

Overview of Obstetrical Care in Orange County

The Orange County Health Planning Council has published a significant amount of information necessary to an understanding of the obstetrical care problem in the county. In 1973 there were 22 hospitals with obstetrical facilities in Orange County. From 1960 to 1973 there was a 25 percent decline in the birth rate in the United States. During that same time in Orange County there was a 45 percent decline in the birth rate. In 1970 there were 25,506 births in Orange County. In spite of the large increase in population in Orange County, the number of births was down to 22,729 by 1973. The birth rate in the county fell from 17.9 in 1970 to 14.0 per thousand population in 1973. In 1973 there were five facilities in each of which there were more than 1,000 live births in Orange County. In four of the five there were more than 2,000 live births. Eleven facilities accounted for fewer than 600 deliveries each per year. The five facilities with more than a thousand births accounted for more than 50 percent of the total births in the county. There are two certified neonatal intensive care units in the county at this time. The two units are the University of California, Irvine, Medical Center and the Children's Hospital of Orange County.

Critical Problems and Physicians in Private Practice

Although many hospitals claim that obstetrics is a losing proposition financially, most still do not want to give it up. The reason for this is mainly the fear of losing lucrative gynecology since many physicians find it convenient to do all their work in one location. This partially explains why in 1973 there was a 43.9 percent obstetrical occupancy rate in Orange County and in spite of this low occupancy rate, construction to provide 80 more beds was under way at the end of 1973. Of interest is that federal standards for obstetrical occupancy rate is at least 75 percent occupancy. In summary, one of the things that has to be examined is the question of how a hospital can give up obstetrics without fear of losing income from gynecology.

The question of staff privileges at a regional center is another point of controversy. This may be a great source of anxiety, particularly for general practitioners providing obstetric or pediatric care. Safeguards for these physicians must be established to ensure that they are allowed to continue practicing. It seems likely that this problem could be resolved by establishing a close working

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relationship between the primary physician and consulting obstetrican, perinatologist or neonatologist. A system can be designed in which a patient understands that her doctor is still taking care of her but that a consulting physician may also be involved.

Social and religious aspects of regionalization are another source of anxiety. For example, obstetricians may be concerned about the situation of a high-risk patient who desires postpartum sterilization either at the time of cesarean section or immediately following delivery in a regional center which for religious reasons does not allow sterilization. There appears to be a great deal of resistance among many obstetricians concerning delivery of high-risk patients where there is no opportunity to do postpartum sterilization. Their argument is further strengthened by the fact that in high-risk mothers there often is a strong medical indication for sterilization.

Another concept that has to be explored is the question of whether there is a minimum number of births necessary before a regional center can be established. There are some excellent hospitals in Orange County that do not have 2,000 or more deliveries per year. Representatives from these hospitals feel that they have the necessary facilities and that in due time they indeed would build up their census. They ask why their hospitals should be penalized now, and never be given an opportunity to develop into regional centers. They feel that in the future they could attract obstetricians from other hospitals and build up a sizable census. This argument is a sound one and this is the way some centers will evolve.

One subject that deserves close attention is the economic factors involved in regionalization. It is well known that a hospital chosen as a regional center probably will be the recipient of large amounts of money both from the government and private philanthropic sources. The physician himself may find that third party payment for high-risk pregnancies may be contingent upon delivery at a regional center. Since all pregnancies are potentially high risk, it is not difficult to envision third party payment only when a baby is delivered at a regional center. Another financial aspect that should be considered is the large amount of money that will be necessary to pay for continuous obstetrical anesthesia coverage, for a neonatologist and for the sophisticated equipment and maintenance of this equipment. It would seem likely that only a regional center with a large volume and perhaps extra income from private and governmental sources would be able to maintain such services and equipment.

In some states, regionalization has been forced by the state by selectively licensing hospitals based on certain guidelines. The fact that hospital obstetrical and pediatric sections require periodic review for relicensure may prove to be a strong force in the regionalization program in this county.

The final question that must be discussed concerning regionalization is perhaps the one provoking most anxiety. Physicians are concerned about who picks the center, where it will be and how many others there will be. The answer is that no one picks the center. The administration of a hospital in each community will have to decide that it will lead the way by upgrading the hospital's facilities according to prescribed guidelines. This should in effect draw physicians from other surrounding hospitals with inferior facilities and consequently a center will develop. Superimposed upon this natural evolution of a center might be the state's refusal to relicense some smaller hospitals with lesser facilities.

Results of the OCMA Questionnaire

The Orange County Medical Association, in cooperation with the Orange County Obstetrical and Gynecological Society and the Orange County Pediatric Society, submitted a questionnaire to all practicing obstetricians, pediatricians and family practitioners in the county. A total of 600 letters were sent out, of which at least 237 were answered. Each respondent was asked to indicate whether he practiced pediatrics only or obstetrics only, or whether he was in general practice providing obstetric services with or without pediatric care. The last category was general practitioners providing pediatric care only (Tables 1 through 7).

- *Question 1. Are you in favor of setting up one hospital in each region or community where you would do all your deliveries?*

Replying in the affirmative were 113 physicians, replying in the negative were 79.

The obstetricians as a group were very much in favor of such a plan, with 59 for and only 14 against. The pediatricians were almost equally divided, with 25 for and 19 against. The general practitioners were somewhat negative with 16 for and 25 against among the general practitioner-obstetricians and with 12 for and 21 against among those general practitioners providing pediatric care only.

TABLE 1.—*Are you in favor of setting up one hospital in each region or community where you would do all your deliveries?*

Total Yes	113	*Total No*	79
Pediatrics Only		*OB Only*	
Total Yes	25	Total Yes	59
Total No.	19	Total No	14
GP-OB		*GP-Peds*	
Total Yes	16	Total Yes	12
Total No	25	Total No	21

- *Question 2. Are you in favor of full-time obstetrical anesthesia coverage which would be essential to such a center?*

Across the board the respondents strongly endorsed such a concept. In all, 179 were for this proposal and only 29 against it. Among the pediatricians 50 were for it and only 2 against it. Among the obstetricians, 70 were for and there were 5 against it.

TABLE 2.—*Are you in favor of full-time obstetrical anesthesia coverage which would be essential to such a center?*

Total Yes	179	*Total No*	27
Pediatrics Only		*OB Only*	
Total Yes	50	Total Yes	70
Total No	2	Total No	5
GP-OB		*GP-Peds*	
Total Yes	28	Total Yes	34
Total No	11	Total No	9

- *Question 3. Are you in favor of a full-time obstetrician, pediatrician and/or perinatal specialist with commitment to high-risk perinatal care to be available for consultation at all times?*

In this case the answer was overwhelmingly yes, with 201 for and only 25 against. Among the pediatricians, 63 were for and only 3 against. Among the obstetricians 66 were for and only 8 against.

TABLE 3.—*Are you in favor of a full-time obstetrician, pediatrician and/or perinatal specialist with commitment to high-risk perinatal care to be available for consultation at all times?*

Total Yes	201	*Total No*	25
Pediatrics Only		*OB Only*	
Total Yes	63	Total Yes	66
Total No	3	Total No	8
GP-OB		*GP-Peds*	
Total Yes	32	Total Yes	41
Total No	7	Total No	7

- *Question 4. Are you in favor of at least one full-time neonatal specialist with 24-hour coverage for high-risk deliveries?*

This concept was heartily endorsed, with 192 for and 33 against. Among the pediatricians, 58 were for and 8 against. Among the obstetricians, 67 were for and 7 against.

TABLE 4.—*Are you in favor of at least one full-time neonatal specialist with 24-hour coverage for all high-risk deliveries?*

Total Yes	192	*Total No*	33
Pediatrics Only		*OB Only*	
Total Yes	58	Total Yes	67
Total No	8	Total No	7
GP-OB		*GP-Peds*	
Total Yes	29	Total Yes	38
Total No	11	Total No	7

- *Question 5. Are you in favor of fetal monitoring to be carried out on most patients in labor?*

A total of 158 respondents were for this and 57 were against. Of the pediatricians, 56 were for, and only 6 were against this proposal. The obstetricians had 53 for and 21 against.

TABLE 5.—*Are you in favor of fetal monitoring to be carried out on most patients in labor?*

Total Yes	158	*Total No*	57
Pediatrics Only		*OB Only*	
Total Yes	56	Total Yes	53
Total No	6	Total No	21
GP-OB		*GP-Peds*	
Total Yes	24	Total Yes	25
Total No	1	Total No	16

- *Question 6. Are you concerned about a possible weakening of the traditional physician-patient relationship?*

In all, 111 of the respondents felt that there was a cause of concern in this regard and 117 felt there was not. Among the pediatricians 23 were concerned, 38 were not concerned. Among the obstetricians 34 were concerned and 41 were not concerned. Among the general practitioner-obstetricians 29 were concerned and 15 were not. Among the general practitioner-pediatricians 25 were concerned and 23 were not.

TABLE 6.—*Are you concerned about a possible weakening of the traditional physician-patient relationship by such a program?*

Total Yes	111	*Total No*	117
Pediatrics Only		*OB Only*	
Total Yes	23	Total Yes	34
Total No	38	Total No	41
GP-OB		*GP-Peds*	
Total Yes	29	Total Yes	25
Total No	15	Total No	23

- *Question 7. Should regional centers be open to all physicians practicing obstetrics and pediatrics?*

The reply in this case was rather one sided. Of the respondents, 196 said yes and only 29 said no. Among the pediatricians 54 said yes, 11 said no. Among the obstetricians 64 said yes, 11 said no. Among the general

practitioners practicing obstetrics 38 were in favor of this, one was against. Among the general practitioners practicing pediatrics 40 were in favor of open centers and 6 were against.

TABLE 7.—*Should regional centers be open to all physicians practicing obstetrics and pediatrics?*

Total Yes	196	*Total No*	29
Pediatrics Only		*OB Only*	
Total Yes	54	Total Yes	64
Total No	11	Total No	11
GP-OB		*GP-Peds*	
Total Yes	38	Total Yes	40
Total No	1	Total No	6

There were many written comments and some of the more frequent replies have been summarized. In response to the first question concerning the acceptance or rejection of a regional center, most physicians said they favored the concept of a regional center. However, many felt confused as to how you define a regional center, how big the region should be, what areas are involved and how many centers there would be. As to the second question concerning full-time obstetrical anesthesia, again most people liked the idea. Of particular concern is the fact that soaring malpractice insurance costs have prompted some anesthesiologists to reconsider full-time obstetrical anesthesia coverage.

In regard to the third and fourth questions concerning the availability of perinatal and neonatal specialists for consultation, most respondents were favorably inclined provided that it was made clear to the patient that the consultant only consulted and that the primary physician was still managing the case. In response to the question of fetal monitoring to be carried out on most patients in labor there were several comments. Some felt that fetal monitoring was necessary only when indicated. Others felt that it was causing unnecessary cesarean sections. Some physicians were concerned that permanent records of monitoring could result in subsequent litigation if an unusual pattern was noted in a child in whom a physical or mental problem later developed.

Question number six inquired as to concern about a possible weakening of the traditional physician-patient relationship by such a program. Here there was a great deal of comment. There was concern about full-time physicians and nurses and about possible friction as to who exercises ultimate control over the patient. Many stressed the point that privileges for all physicians bringing patients to regional centers must be guaranteed. One general practitioner who practices obstetrics and pediatrics said, "We must resist regional programs, they are another lock on the door of the practice of medicine as we know it." Another physician put it another way, "Consultants should remain consultants and clearly identifiable as such." Another physician answered the question this way, "Leave me alone." In short, there was a good deal of anxiety concerning the traditional physician-patient relationship if this program goes into effect. Physicians were worried that they would lose their patients and that they would lose control and management of patients—in short, that they would lose their independence.

The final question was: "Should regional centers be open to all physicians practicing obstetrics and pediatrics?" Nearly everyone agreed that this should be true, although many replied that physicians should be qualified to practice in these places by virtue of boards, board eligibility or proven practice experience. Many felt that continuing education programs would close any gaps. General practitioners most of all were extremely concerned about this. One suggestion was to write it into the bylaws that primary physicians should always be in charge and that they would call consultants as needed, which is essentially the way it is done at present. Another physician felt that centers should be open to everyone but with regular performance reviews. Some indicated that in cases of high-risk pregnancy, they would refer the patient to a specialist anyway. Many stressed that policies should be made with all practicing clinical physicians in the community represented, and that this should include general practitioners. A general practitioner practicing only pediatrics put it this way, "The concerned hospitals together with the Orange County Medical Association should guarantee the qualified physician the right to practice in the center in his region." A few physicians were very concerned that there was, as one said, "no single way to protect ourselves in keeping a center such as this open to all." Some felt that this was opening the door to socialized medicine. A general practitioner practicing obstetrics and pediatrics put it this way, "Privileges must be based on provable capability, not specialty society membership. Family physicians should be monitored by qualified family physicians until approved. Obstetricians should be monitored by obstetricians until skill is demonstrated." Some people thought that the whole business was non-

sense because in most cases patients do not require care in sophisticated treatment centers. It is true that 90 percent of deliveries are routine but unfortunately we have no way of identifying in advance most of those mothers or babies in whom difficulties will develop. As long as this is a fact then every patient must be considered high-risk and centers used for delivery.

Summary

In summary, after reviewing the results of this questionnaire, it is apparent that the physicians in Orange County are in favor of the best possible pediatric and obstetrical care available. Some feel that a regional center will not improve care. Many feel that such a situation would destroy the traditional physician-patient relationship. Most feel that if such centers are established, they must be open to all physicians. Many have voiced grave concern that this would give an entree to socialized medicine.

After talking to many people and studying the data, it is the authors' opinion that certain concepts must be accepted if regionalization of perinatal care is to become a reality in Orange County. A system must be designed in which private practitioners are guaranteed the right to practice in such a center. All administrative controls must come ultimately from those in private practice. Reviewing should be by peer review of other practitioners. Both consultants and patients must clearly understand who the primary physicians are and that the consultants are no more than that. Many of the respondents also have emphasized that governmental control should be left out of this system. It should be understood from the beginning that any funds from government should not have any strings attached which might jeopardize control by the practicing physicians themselves. If such assurances can be given, we think that there will be no reservations about this concept of regionalized care in Orange County.

Mesenteric Venous Thrombosis and the Pill

The thing that worries me about mesenteric venous thrombosis is that it's been reported in young women taking contraceptive pills . . . It's a very serious problem and I should suggest that in any woman taking contraceptive pills who's having severe bouts of recurrent pain, one might suspect at least the possibility that it's related to this process. It has an insidious onset. It has a very poor survival rate because frequently it's not picked up early enough. And it's frequently associated with rather serious diseases anyhow.

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